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MEMORANDUM

TO: Legislative Oversight Committee Members
Commission for MH/DD/SAS
Local CFAC Chairs
State CFAC
NC Council of Community Programs
NC Assoc. of County Commissioners
County Managers
County Board Chairs
State Facility Directors
LME Directors
LME Board Chairs
DHHS Division Directors
Advocacy Organizations
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations

FROM: Allen Dobson, MD LAD mb

Mike Moseley MM

SUBJECT: Enhanced Services Implementation Update # 6: Consumers' Choice of Provider, Subcontracting, Caseload Ratios, Questions & Answers

Consumer Choice

One of the principles of a consumer-focused system is the ability of consumers to choose their service provider. We are committed to this "freedom of choice" requirement. As we transition into the new service array on March 20, 2006 we want to ensure that consumers have the ability to exercise their freedom to choose from among all willing and qualified providers, while also ensuring that consumers don't experience a loss of service if they do not make a provider choice.

For most of the new services that "crosswalk" to an existing service, the assumption will be that unless the consumer indicates otherwise, they choose to continue in service with their current provider. For example, a consumer attending a Psychosocial Rehabilitation program on March 19

will be assumed to want to participate in the same program on March 20, unless they request a change of provider.

The exception to this assumption will be for consumers currently receiving case management and Community Based Services (CBS). For most consumers with mental illness or substance abuse needs, these services will transition on March 20 to the new Community Support service. It is critical as this transition occurs that safety and continuity of care for consumers and families, along with consumer choice, remain the goals of the transition. It is quite likely that consumers receiving case management and CBS currently receive those services from different providers. It is also likely that both of those providers are seeking endorsement to provide Community Support. Assuming that both providers are endorsed, consumers may choose to receive Community Support from either of their current providers or from any other qualified Community Support provider. Community Support is a critical component of the new service delivery system since it will serve as the "clinical home" for many of our target population consumers and their families. The early identification and assignment of Community Support service will provide for the safety and continuity of services to support families through the transition period.

Local Management Entities (LME) and providers currently providing case management and CBS are encouraged to discuss this transition with the consumers they serve. **We are encouraging informed choice by consumers of an endorsed Community Support provider as quickly as possible.** Consumer choice of a new provider may occur at anytime, as long as the provider is endorsed by the LME to provide the requested service.

In the event a consumer does not choose a Community Support provider by March 15, 2006, an assignment of provider should be made by the LME, using the following guidelines:

1. If case management and CBS are currently being provided to a consumer by the same provider, the assumed choice will be the current provider.
2. If case management and CBS are provided to the consumer by different agencies, the assumed choice will be the provider of the case management services.
3. If case management is provided by the LME and CBS has been provided by a community provider, the assumed choice will be the agency providing the CBS service.

We are attaching to this memorandum a document that can be given to consumers and families to help them as they consider solicitations from provider organizations.

Subcontracting

A lot of questions have been raised regarding whether or not it is permissible for providers to subcontract with other providers for staff to deliver the new services. This is not a question with a simple "yes or no" answer. Rather than examining the nature of the employment relationship, the important consideration is the way the service will be delivered. The analogy we use is the common practice of employing "traveling nurses" in a hospital setting. The consumer in the hospital can't tell which nurses work directly for the hospital and which work for a nurse staffing provider; to the consumer they are all working together to provide a hospital service.

Community Support is designed to be a comprehensive, integrated service. If the Community Support provider has some staff on its payroll and others for whom it contracts but all of the staff work together and function as a team, and it is invisible to the consumer who works for which

organization, the contractual nature of some of the staff is irrelevant. Conversely, if a provider who currently provides only case management applies for endorsement to provide Community Support with a plan to subcontract with a current provider of CBS for the skill-building aspects of the definition, and it is clear that they plan to continue to deliver the service as if it were two separate services, the arrangement would not be appropriate or allowable.

Diagnostic Assessment, ACTT, Mobile Crisis and other services requiring a physician may very well be delivered by providers who contract with psychiatrists - or organizations employing psychiatrists, such as the LMEs - for the physician coverage required by the service definitions. As long as the psychiatrist functions as a member of the team, such an employment relationship is absolutely allowable.

Caseload Ratios for Community Support

We have received a number of questions about the caseload ratios for the Qualified Professionals (QP) delivering Community Support Services for children/adolescents and adults. The definition for Community Support Child/Adolescent has a consumer to QP caseload of 15:1 and the one for Community Support Adult has a consumer to QP caseload of 30:1. The definitions also require that all consumers receiving the service have a minimum of two 15-minute contacts per month. In addition, the definitions permit up to 8 units, or two hours, per month to be billed for children in residential placement to continue to keep them connected to their home community and as a consumer transitions to or from other services. We believe the service rates have been developed to adequately address the caseload ratios for most consumers receiving Community Support. However, we recognize that counting consumers receiving two hours or less of services as part of the caseload ratio computation could create financial problems for the provider agency. In order to address this concern, we have agreed that a QP delivering Community Support Child/Adolescent may have a caseload of no more than 15 "full time" consumers **and** no more than 10 consumers receiving two hours of service or less per month. A QP delivering Community Support Adult may have a caseload of no more than 30 "full time" consumers **and** no more than 15 consumers receiving two hours of service or less per month.

Questions and Answers

DMA and DMH/DD/SAS staff have collaborated to answer all of the questions regarding the new service definitions that were generated in the January trainings. The "Q&A" document has now been posted to both Divisions' websites: http://www.dhhs.state.nc.us/dma/MentalHealthlink.htm and http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm.

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